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FILED
MAR 31 2008
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 06-923

IN THE SUPREME COURT OF THE UNITED STATES

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,
Petitioners,

v.

WANDA GLENN,
Respondent.

On Writ of Certiorari To The United States Court of Appeals For the Sixth Circuit

BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF RESPONDENT URGING AFFIRMANCE

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INTEREST OF *AMICUS CURIAE*[1]

AARP is a nonpartisan, nonprofit membership organization of nearly 40 million persons age 50 or older, more than half of whom are employed. AARP is dedicated to addressing the needs and interests of older persons. Countless members participate in employer-funded health, pension, disability, and other employee and retiree benefit plans. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all. In its efforts to foster the economic security of individuals as they age, AARP seeks to increase the availability, security, equity, and adequacy of public and private pensions, health, and other employee benefits.[2]

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[1] The parties have consented to the filing of this brief. *Amicus curiae* AARP states that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission.

[2] As part of its advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP has participated as *amicus curiae* in numerous cases involving the scope of a fiduciary's duties, the appropriate standard of judicial review of plan administrators' benefit eligibility determinations under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and the scope of remedies available under ERISA's civil enforcement provisions. *See, e.g., LaRue v. DeWolff*, Boberg & Assocs., 552 U.S. _, 128 S. Ct. 1020 (2008); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Abatie v. Alta Health*

(continued...)

Given the exclusivity of ERISA's civil enforcement provisions for participants in employee benefit plans, see *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004), it is imperative that participants have meaningful recourse under ERISA to protect and enforce their rights under such plans. The issues in this case directly bear on the standard of review applicable to a benefit denial by a plan administrator. Thus, resolution of the issues in this case will have a significant impact on the integrity of the administration of employee benefit plans and individual participants' abilities to obtain those benefits which will foster their economic security. AARP, therefore, submits its brief amicus curiae to facilitate a full consideration by this Court of these issues.

SUMMARY OF ARGUMENT

An inherent conflict of interest exists when an ERISA benefit plan administrator also funds plan benefits because a plan administrator cannot act in its own financial interest while simultaneously acting in the best interests of plan participants. The recognition of such a conflict is supported by the language and legislative history of the ERISA statute and by age old common law principles founded in trust law and contract law. The text and history of ERISA's civil enforcement provisions also indicate an affirmative mandate that the *de novo* judicial standard of review is applicable in the district courts to participants' challenges to benefit denials by plan administrators operating under a conflict of interest.

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[2](...continued)
& Life Ins. Co., 458 F.3d 955 (9th Cir. 2006) (en banc); *Milofsky v. Am. Airlines*, 442 F.3d 311 (5th Cir. 2006); *In re Schering-Plough ERISA Litig.*, 420 F.3d 231 (3d Cir. 2005); *Callery v. U.S. Life Ins. Co.*, 392 F.3d 401 (10th Cir. 2004); *Steinman v. Hicks*, 352 F.3d 1101 (7th Cir. 2003).

ARGUMENT

I. AN ADMINISTRATOR THAT BOTH EVALUATES AND PAYS CLAIMS UNDER A PLAN GOVERNED BY ERISA IS, WITHOUT MORE, OPERATING UNDER A CONFLICT OF INTEREST THAT MUST BE WEIGHED ON JUDICIAL REVIEW OF A BENEFIT DETERMINATION.

A. ERISA's Statutory Text Compels The Inescapable Conclusion That A Conflict Of Interest Attaches When A Plan Administrator Is Also The Funding Source For Plan Benefits.

Under ERISA § 404(a), 29 U.S.C. § 1104(a), "a fiduciary shall discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and for the *exclusive purpose* of providing benefits to participants and their beneficiaries. . . ." (emphasis added). Plan administrators that also serve as the funding source for benefits have a concurrent and conflicting financial interest in the outcome of their benefit eligibility determinations. Indeed, a majority of the Courts of Appeals have concluded that a plan administrator that also funds plan benefits operates under a conflict of interest that courts must take into account on judicial review. *See Post v. Hartford Ins. Co.*, 501 F.3d 154, 161-64 (3d Cir. 2007); *Carolina Care Plan Inc. v. McKenzie*, 467 F.3d 383, 386-87 (4th Cir. 2006); *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 295-96 (5th Cir. 1999) (en banc); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-66 (9th Cir. 2004) (en banc); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561, 1566-67 (11th Cir. 1990).

B. The Court's Decisions Recognize A Fundamental, Immutable Principle That A Person Cannot Concurrently Serve Two Masters With Conflicting Interests.

It is natural to view the legal role of a plan administrator under an ERISA plan as that of an agent of the plan, who is bound to conduct itself in accordance with the ERISA imposed duty to fulfill the plan's statutorily required purpose, i.e., to "discharge his duties *solely in the interest of the* [plan's] *participants and beneficiaries* and . . . for the exclusive purpose of . . . *providing benefits to* [plan] *participants and their beneficiaries* . . . . § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A) (emphasis added). Thus, it is no stretch of law or analysis to invoke in the ERISA dual role context the general rule that a person cannot simultaneously serve "two masters with opposed interests." *United States v. Miss. Valley Generating Co.*, 364 U.S. 520, 550 (1961); *see also NLRB v. Town & Country Elec., Inc.*, 516 U.S. 85, 93 (1995).

> Since . . . the relation of master and servant is dependent upon the right of the master to control the conduct of the servant in the performance of the service, giving service to two masters at the same time normally involves a breach of duty by the servant to one or both of them . . . . [A person] cannot be a servant of two masters in doing an act as to which an intent to serve one necessarily excludes an intent to serve the other.

NLRB v. Town & Country Elec., 416 U.S. at 93 (quoting Rest. 2d Agency § 226, Comment *a*, at 449 (1957)). Contrary to the insistence of Petitioners at Page 21 of their brief that Congress made it clear that "it did not consider a fiduciary that is separately responsible for paying the claims that it reviews to be

acting 'in [its] own interest.'" Neither ERISA's statutory text nor any decision of this Court validates Petitioners reading of *Pegram v. Herdrich,* 530 U.S. 211 (2000) (emphasis added). *Pegram* does not support the proposition that the determinations of a benefit plan administrator which evaluates eligibility and also pays benefits escape characterization as conflicted. *Pegram*, after all, was a claim seeking to establish fiduciary liability under ERISA § 409(a), 29 U.S.C. 1109(a), and that case held no more than that mixed decisions by HMO physicians are not fiduciary decisions under ERISA. Petitioners' contention that from *Pegram*'s holding the Court must leap to the conclusion that benefit eligibility decisions by insurance company claims managers on ERISA claims brought under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), are without conflict cannot withstand analysis. *Brief of Petitioners* at 21.

The functional plan administration work of evaluating benefit claims is conducted primarily by benefit claims managers, employees of plan administrators who frequently work pursuant to financial incentive schemes that may reward them for effective denial or termination of claims. To compare their status under ERISA to physicians employed by an HMO that pays year-end bonuses based upon the HMO's profitability performance is to miss the point of *Pegram*'s holding and to ignore the fact that the medical treatment decisions made by the physician at issue in *Pegram* were subject to any number of separate external standards of professional performance as well as to external accountability. In contrast, claims managers have virtually none of either.

External controls over physicians are numerous. For example, all practicing physicians are sworn under the Hippocratic oath to act in the interests of their patients. Moreover, practicing physicians in all jurisdictions are subject to mandatory qualification

and licensure standards as set by their respective practice jurisdictions. Furthermore, physicians are subject to professional performance standards manifest in the standard of care recognized in the respective localities in which they practice, and they are accountable under the respective tort law regimes applicable to them for departures from those standards. No such external regime of performance standards or outside institutional accountability attaches to the decisions of benefits claims managers. To the contrary, ERISA's expansive preemption shield virtually insulates claims managers from any accountability whatsoever in the event of a departure from non-conflicted eligibility decision-making. *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

In light of ERISA § 404(a)'s statutory command to plan administrators of loyalty to the interests of plan participants and beneficiaries, a plan administrator's obligations to participants and beneficiaries, coupled with an administrator's for-profit operating imperative and concurrent responsibilities to its equity holders, casts a classic example of service to one master that requires abandonment of service to the other. The interests of beneficiaries and the funding source are directly antagonistic, as any payment to the beneficiary derives from the plan administrator's financial resources. Furthermore, the prospect of financial incentives for benefits claims managers on account of aggressive and payment-saving performance exacerbates the conflict.

It is no answer to say that every commercial transaction that pits parties at arms length inherently has the same type of tension as the dual role ERISA plan administrator. Here, the plan participant's claim under an ERISA employee benefit plan is not a typical commercial transaction in any sense. In the first place, the plan administrator and the claimant cannot be said to stand at arms length, as the claimant did not negotiate the contract with the plan administrator.

Instead, the relationship is typically governed by a group contract that lays out the terms of the contract including the judicial standard of review and certain claims procedures by which the claimant is bound. The claims procedure in the vast majority of cases creates a permanent, comprehensive record upon which the claim will be decided.

The entirety of the claims process is administered by the plan administrator, who decides what constitutes the record and ultimately makes a determination of eligibility, i.e., decides whether to pay the claim. Lacking from the entire process is any neutral party without a stake in the outcome of the claim. In the event the claimant believes he or she is aggrieved at the conclusion of the administrative process, which includes an administrative appeal (also administered and adjudicated by the plan administrator), then under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), the claimant may challenge the claim administrator's determination by filing an ERISA civil enforcement suit in federal court. In such a challenge the claimant generally may not supplement the substantive record upon which the claim was decided. And in the claimant's civil enforcement proceeding under ERISA, it is typical for the court to review the determination of the plan administrator under an arbitrary and capricious standard, i.e., with a view highly deferential to the plan administrator.

Petitioners point to the absence in ERISA's prohibited transaction rules of any provision making both evaluating and paying benefits a *per se* prohibited transaction as support for the conclusion that no conflict inheres in that dual role status. *Brief of Petitioners* at 21-22. Although the prohibited transaction rules do not specifically bar such dual roles in plan administration, this fact stems in large part from the historical fact that the enactment of ERISA was driven primarily by Congressional concern for the

integrity of retirement pension funding. In that context it was and is plainly foreseeable that employers would act as plan administrators of the same pension benefits that they undertake to fund for their employees, both of those roles being incidental to the employer's primary line of business. That scenario is altogether different in kind from the delegation of plan administration and plan funding by employer sponsored group insurance plans to third parties for health, life, and disability coverages. Dual role plan administrators are frequently insurance companies such as Petitioner MetLife here, whose profit is *primarily* derived from claims administration and benefit funding. In such situations, the plan administrator may well have far less at stake in meeting the reasonable expectations of the employees, who are the participants and beneficiaries of the employer sponsored plans that they administer and fund, than they have to gain from unduly hard-nosed plan administration and parsimonious benefit payment practices. Unlike the employers to whom they sell their services, the very business success of these hired plan administrators may well be driven by their claim evaluation and payment experience. *Amicus* submits that the prohibited transactions provisions were drafted with a view to practicality for the commonplace situation of the employer-plan sponsor rather than with the intention of exonerating third party plan administrators from traditional conflict of interest standards. Clearly, a dual role insurer such as Petitioner MetLife operates under a conflict of interest that a court must consider in reviewing benefit denials.

II. A PARTICIPANT WHO HAS BEEN DENIED BENEFITS UNDER AN ERISA PLAN IS ENTITLED TO *DE NOVO* JUDICIAL REVIEW OF THE BENEFIT ELIGIBILITY DETERMINATION.

Congress enacted ERISA to protect participants' and beneficiaries' interests in employee benefit plans by setting out substantive regulatory requirements, including standards of conduct, responsibility, and obligation for fiduciaries and to provide for appropriate remedies, sanctions, and ready access to the federal courts. ERISA § 2(b), 29 U.S.C. § 1001(b); *Davila*, 542 U.S. at 208; *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 264 (1993).

A. ERISA's Text Contemplates *De Novo* Review Of Benefit Eligibility Determinations.

"The starting point in every case involving construction of a statute is the language itself." *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756 (1975); *Larue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. __, 128 S. Ct. 1020 (2008) (Thomas, J. concurring); *Inter-modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510 (1997). The language of ERISA demonstrates that Congress viewed benefit claims as questions of entitlement to "contractually authorized benefits," *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985), to be reviewed *de novo* by the courts.

Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), provides that a participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of his plan [or] to enforce his rights under the terms of the plan." (emphasis added). The plan itself must be "established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), which must "specify the basis on

which payments are made . . . from the plan," 29 U.S.C. § 1102(b)(4). These provisions spell out a statutory scheme under which a participant's entitlement to benefits must originate from a written plan–which may be presumed to be a trust instrument or a contract–and under which a participant may bring a civil action to compel payment of such benefits.

In contrast to the provision authorizing a participant to bring a civil action to recover benefits due under a plan, sections 502(a)(2) & (3) authorize civil enforcement proceedings to be brought by named persons to redress fiduciary misconduct. This Court has recently held that actions seeking relief against fiduciaries must be brought on behalf of the plan, even if the ultimate recovery is to inure to a single participant account. *Larue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. __, 128 S. Ct. 1020 (2008). The textual differences of the respective provisions are instructive. Section 502(a)(1)(B) empowers the participant to enforce his rights. The notion of enforcement is inconsistent with an administrative regime of the sort that ties the participant's legal rights to a court's deferential review of a dual role administrator's eligibility determination. A comparison of the language of the respective civil enforcement provisions contemplates an equitable type of action for sections 502(a)(2) & (3), but a distinctly legal type of action and remedy under section 502(a)(1)(B).

Firestone's reliance on principles of trust law in navigating to its holding that *de novo* is the default standard of review for section 502(a)(1)(B) claims appears to be soundly grounded in ERISA's textual language and the avowed Congressional purpose. It is an open question whether the Court deems it prudent to continue to stand by *Firestone*'s embrace of trust law principles for all purposes in sorting out the respective rights of plan participants and plan administrators in ERISA enforcement proceedings.

This is particularly true in determining the appropriate standard of review for actions under section 502(a)(1)(B) when the plan administrator is charged both with evaluating and paying claims.

Firestone, albeit in *dicta*, endorses the principle that all plan administrators are created equal, that impartiality of plan administrators is of no concern, and that the motivations of plan administrators and fiduciaries is irrelevant. Plan administrators have seized upon these dicta in *Firestone* to subvert ERISA's explicit mandate "to promote the interests of employees and their beneficiaries in employee benefit plans," *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983) and to "protect contractually defined benefits," *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. at 148.[3/]

Petitioners' argument that courts should defer to conflicted plan administrators' eligibility determinations is essentially a plea that the industry must be trusted to do the right thing. One need not look beyond simple human nature to recognize that a company whose primary interest is profit-maximization will be tempted to deny meritorious claims in bad faith to avoid profit loss. *See Watson v. UnumProvident Corp.*, 321 F. Supp. 2d 226, 247-48 (D. Mass. 2004) (recognizing a pattern of bad faith denials by a plan adminsitrator that also served as the funding source for benefits); *Brigham v. Sun Life of Can.*, 317 F.3d 72, 85-86 (1st Cir. 2003) (commenting that, under the arbitrary and capricious standard of review, it was bound to affirm the "counterintuitive" but not

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[3/] Petitioner MetLife argues that the realities of the insurance business are that the "long-run reputational incentives for insurance companies to review benefit claims in an equitable manner counteract the purely theoretical short-term interest that a company may have to minimize payouts by denying meritorious claims." *Brief of Petitioners* at 30.

unreasonable decision of the plan adminsitrator to deny benefits); *Prado v. Allied Domecq Spirits & Wine Group Disability Income Policy*, No. C-05-2716, 2008 WL 191985, at *4 (N.D. Cal. Jan. 22, 2008) (holding that the plan administrator's conflict of interest as the fiduciary of the plan and funding source for benefits improperly influenced its decision to deny the claim at issue).

The Unum/Provident scandal provides a distressing example of the mischief that results from allowing plan administrators that also serve as the funding source for benefits to take advantage of a discretionary standard of judicial review. Unum's financial self-interest dictated its claims denial process and Unum maintained a practice of denying claims in bad faith. *See Watson*, 321 F. Supp. 2d 226. In *Watson*, the court cited an impressive list of cases that "reveal[ed] a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics." *Id.* at 247-48. Several states also launched investigations into Unum's questionable claims administration practices, many of which imposed significant fines on Unum for its wrongful denial of meritorious claims. *See, e.g.*, Maine Bureau of Insurance, *Report of the Targeted Multistate Market Conduct Examination*, http://www.maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (last visited Mar. 28, 2008). *See generally*, John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, 1317-21 (2007).

Given that "ERISA abounds with the language and terminology of trust law," this Court has held that "the courts are to develop a federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 110 (1989). Because ERISA is silent regarding the

standard of review for benefit appeals in federal court, reviewing a plan administrator's benefit denial under an arbitrary and capricious standard is merely judicially created law. *See id.* This Court has never mandated deferential review of a plan administrator's decision; on the contrary, *Firestone* holds that the default standard of review for ERISA claims is *de novo*. Indeed, this Court emphasized that "[w]hatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations*. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (emphasis added)).

B. The District Courts Must Review The Benefit Eligibility Determinations of Conflicted Plan Administrators On A *De Novo* Standard Of Review.

Various competing versions of ERISA's standard of judicial review are urged upon this Court, and at one extreme an arbitrary and capricious standard. In the middle are several variations of sliding scale standards and burden shifting regimes proposed by one party and *amici*. And at the other extreme a standard of *de novo* review is urged. In cases where a plan administrator's interest conflicts with those of plan participants, only the *de novo* standard is consistent with the trust duty of loyalty which Congress made the foundation of ERISA's fiduciary provisions.

The duty of loyalty is "the most fundamental duty owed by the trustee to the beneficiaries of a trust." A. Scott & W. Fratcher, THE LAW OF TRUSTS § 170 (4th ed. 1988). Ordinarily the duty of loyalty does not permit trustees to exercise discretion in a

matter in which the trustee has an interest.[4] *Woods v. City Nat'l Bank & Trust Co.*, 312 U.S. 262, 269 (1941); *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928). Yet MetLife argues that the Court should interpret ERISA's duty of loyalty in a manner that permits a fiduciary to exercise discretion in a decision that pits the fiduciary's interests in avoiding benefit payments against the participants' interest in receiving them.

Petitioners' argument, taken to its logical conclusion, is that Congress intended to undermine the duty of loyalty as applied to conflicted, dual role plan administrators.[5] The only evidence that Petitioners point to in support of this novel assertion is that ERISA permits employees of the employer to serve as plan fiduciaries without causing a *per se* violation of ERISA's prohibited transaction rules. *See* 29 U.S.C. § 1108(c)(3). That section alone is hardly sufficient

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[4] Courts have held that trustees with an interest in conflict with trust beneficiaries must either resign their position, *see, e.g.*, *Fidelity Union Trust Co. v. Johnson*, 55 A.2d 813 (N.J. 1947), or petition the court to make decisions on matters in which the trustees have conflicting interests, *see, e.g.*, *Rogers v. Rogers*, 18 N.E. 636 (N.Y. 1888); *Armington v. Meyer*, 236 A.2d 450 (R.I. 1967), or act only in concert with independent trustees, *Dana v. Gring*, 371 N.E.2d 755, 760 (Mass. 1977).

[5] Brief of Petitioners at 33. Petitioners contend that trust law principles require courts to defer to a fiduciary's decisions "even when the fiduciary has a conflict." Brief of Petitioners at 40. In Petitioners' view, the conflict is only one of many factors to be considered by a court. *Id.* In fact, courts will not permit a trustee with a conflict of interest to take discretionary action unless it is clear that the settlor *intended* the trustee to act despite the conflict. *See* A. Scott & W. Fratcher, THE LAW OF TRUSTS § 187.5 n.5 (4th ed. 1988) (cases cited hold that trustee may act despite conflict of interest only if settlor authorized the trustee to act despite the conflict).

evidence of congressional intent to waive the duty of loyalty, for in such situations, courts

> adhere to the rule of strict construction in favor of the trust . . . . The presumption of the law is against [power to act despite a conflict of interest] and, in the absence of clear provision to the contrary, all doubts regarding the scope of the language upon which the claim for such a power is made must be resolved against the party making the claim.

City Bank Farmers Trust Co. v. Taylor, 69 A.2d 234 (R.I. 1949); *see also* Retirement Income Security Act of 1973, S. Rep. No. 127, 93d Cong., 1st Sess. 2, *reprinted in* I Legislative History 587, 615 (indicating that Congress codified certain trust principles because, *inter alia*, it wished to prevent settlors from exempting fiduciaries from common law trust duties as they had been permitted to do under state law).

Given the lack of clear congressional intent to override the strictures of the duty of loyalty, ERISA should be interpreted in a manner that precludes fiduciaries from exercising discretion on matters affecting their own interests. Accordingly, when plan fiduciaries make decisions affecting their interests, courts must apply a *de novo* standard of review. Any other interpretation of ERISA threatens participant security in the benefits ERISA was enacted to preserve and protect.

C. The Exclusive Purpose Rule Requires *De Novo* Review Of Benefit Denials.

ERISA's exclusive purpose rule requires fiduciaries to administer ERISA plans for the exclusive purpose of providing benefits to participants and their beneficiaries. 29 U.S.C. § 1104(a)(1)(A)(I). A fiduciary's discretionary act must promote this purpose

and no other. A decision to deny benefits to participants does not advance the purpose of providing benefits to participants unless there is a compensating advantage to the plan.[9] A decision to deny benefits in an unfunded plan provides no such compensating advantage and therefore falls outside the range of permissible discretionary acts under the exclusive purpose rule. Thus, courts must consider the benefit dispute as a contractual question subject to *de novo* review.

D. The Deferential Arbitrary and Capricious Standard of Review over ERISA § 502(a)(1)(B) Creates an Illogical Presumption that an Interested Decision Maker Acted Against Its Own Interests.

It is illogical and irrational to assume that an insurance company that acts as administrator and fiduciary of a plan for which it also serves as the funding source will function with the same impartiality as the trustee of a funded plan. To say that it was not the foremost objective of Congress through the enactment of ERISA to ensure fiduciary loyalty and neutrality would deny the statute's essential history and purpose. There is simply no legal or logical reason to view an insurer, such as MetLife is in this case, through the favorable (deferential) lens of fiduciary insofar as the matter at issue revolves around the insurer's denial of benefits, since *Firestone* did not obviate ERISA's fiduciary obligations.

Applying a forgiving deferential standard of review to determinations made by insurers is

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[9] Pre-ERISA cases often held that pension plans should be construed in favor of the employees. *See, e.g., Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1354 (8th Cir. 1980); *Thornberry v. MGS Co.*, 176 N.W.2d 355, 360 (Wis. 1970).

altogether inappropriate because ERISA's mandate of fiduciary responsibility is intended to "provide benefits to as many intended employees as is economically possible while protecting the financial stability of the [plan]." *See Elser v. IAM Nat'l Pension Fund*, 684 F.2d 648, 656 (9th Cir. 1982), *cert. denied*, 464 U.S. 813 (1983). It is axiomatic that the insurer in these circumstances must choose between the interests of individual plan beneficiaries on the one hand and the insurer's desire to produce profits on the other. Surely, the overall purposes of ERISA are best served by instructing reviewing courts to apply *de novo* review in determining whether benefits are due under the terms of the plan. Deference is the judicial equivalent of presuming the correctness of the decision to deny benefits. *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990). Such a presumption in the circumstances of an undeniable disincentive to pay benefits runs the serious risk of upholding decisions in which the interests of plan participants and beneficiaries are sacrificed to the insurer's self-interest. The inherent nature of the conflict faced by administrator-insurers dictates an unqualified rule of no deference in cases where a plan administrator that is also the funding source for benefits denies a benefit claim.

Thus, while *Firestone* recognizes that the language of an ERISA plan document may confer discretion to a Plan administrator or fiduciary so as to trigger a deferential standard of review in a subsequent court challenge to a benefit denial by the fiduciary, this deferential standard should apply exclusively where the fiduciary's only obligation is to safeguard the plan's assets. A third party fiduciary's incentive to increase its profits or conserve its own assets would disqualify that third-party fiduciary's decision from deferential review.

Deference to a conflicted plan administrator tips judicial review in favor of the insurer's decision. *See*

e.g., *Brigham*, 317 F.3d 72. On the other hand, the *de novo* standard does no more than establish a level playing field. In *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355 (2002), this Court observed that the deferential standard for reviewing benefit denials is "a feature of judicial review highly prized by benefit plans." *Id* at 384. This Court emphasized that ERISA is silent regarding a standard of review, and remarked that there is no requirement of a "uniformly lenient regime of reviewing benefit determinations." *Id.* at 385. Instead, the Court reiterated its *Firestone* statement that discretion is a matter of contract and plan design. *Id.* at 386. "Nothing in ERISA, however, requires that these kinds of decision be so 'discretionary' in the first place; whether they are is simply a matter of plan design or drafting . . . ." *Id.* In conclusion, the Court stated that "[d]eferential review . . . is not a settled given." *Id.*

CONCLUSION

AARP submits that an ERISA plan administrator that both evaluates and pays claims is operating under a conflict of interest that must be weighed on judicial review of a benefit determination. A *de novo* standard of review should apply on judicial review of a discretionary benefit determination by a plan administrator so conflicted. For the reasons stated above, AARP respectfully urges the Court to affirm the decision of the Sixth Circuit Court of Appeals.

Respectfully submitted,

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